DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17422

State File No. _____

FILED JUN 8 1943

Registration District No. _____ Primary Registration District No. 1000 *Registrar's No.* 601

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mo. Methodist Hospital
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution Six days
In this community Six days *(Specify whether years, months or days)*

3. (a) PRINT FULL NAME William Thomas Redmon

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Adah Redmon

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased March 1, 1878
(Month)(Day)(Year)

8. AGE: Years 65 Months 3 Days 0
If less than one day hr. ___ min. ___

9. Birthplace Near Craig *(City, town, or county)* Mo. *(State or foreign country)*

10. Usual occupation Farming

11. Industry or business On Farm

FATHER {
12. Name Elvis Granville Redmon
13. Birthplace Unknown Ill.
}

MOTHER {
14. Maiden name Mary Yount
15. Birthplace Cole County Mo.
}

16. (a) Informant's own signature Adah Redmon

(b) Address Craig, Mo.

17. (a) Burial (b) Date thereof 6/1/43 *(Month)(Day)(Year)*

(c) Place: burial or cremation I.O.O.F. near Craig

18. (a) Signature of funeral director Wilber L. School

(b) Address Craig, Mo.

19. (a) 6-1-43 *(Date received local registrar)* (b) Rose Herzog *(Registrar's signature)*

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Holt

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 3½ miles South Craig, Mo.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month June day 1st
year 1943 hour 6 minute 45 P. M.

21. I hereby certify that I attended the deceased from May 25, 1943, to June 1st, 19 43
that I last saw him alive on June 1st, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Myelocytic Leukemia Duration 2 mos.

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death) N/A

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ *(City or town)(County)(State)*

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ *(Specify type of place)*

(e) Means of injury _____

28. Signature _____ M. D. or other)

Address St. Joseph, Mo. Date signed 6-1-43

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....................................

............................My self..., Registered Apprentice No...,

working under my personal supervision.

Signed....*Wilber L. Schooler*............................

Licensed Embalmer No....*3997*................................

P. O. Address.....*Craig, Mo.*................................

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING.** (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.